(G) Fringe Benefits.

1. Life insurance.

2. Retirement plans. Contributions to qualified retirement plans, as determined by the United States IRS, for the benefit of employees of the provider shall be allowable cost area.

(H) Education and Training Expenses.

1. The cost of training which directly benefits the quality of health care or administration at the facility shall be allowable.

2. Cost of education and training shall include travel costs incidental to training but will not include leaves of absence or sabbaticals.

(I) Advertising Costs. Advertising costs which are reasonable, appropriate and helpful in developing, maintaining and furnishing services shall be an allowable cost area. The costs must be common and accepted occurrence in the field of the activity of the provider.

(J) Central Office and State Central Service Costs. Costs which are appropriately distributed to the provider as direct costs, properly allocated to the provider, or allocated in accordance with approved cost allocation plans when plans are required, shall be allowable.

(K) Utilization Review. Incurred cost for the performance of required utilization review for ICF/MR is an allowable cost area. The expenditures must be for the purpose of providing utilization review on behalf of Title XIX recipients. Utilization review costs incurred for Title XVIII and XIX must be apportioned on the basis of reimbursable recipient days recorded for each program during the reporting period.

(L) Minimum Utilization. In the event the occupancy utilization of a provider is below ninety percent (90%) of its certified bed capacity, appropriate adjustments shall be made to the allowable cost areas of the provider. Fixed costs will be calculated as if the provider experienced ninety percent (90%) utilization. The fixed costs are laundry, housekeeping, general and administrative and plant operation costs. Variable costs will be calculated at actual utilization. The variable costs are nursing, dietary and ancillary costs. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(M) Nonreimbursable Costs.

1. Bad debts, charity and courtesy allowances are deductions from revenue and are not to be included as allowable costs.

2. Those services that are specifically provided by Medicare and Medicaid must be billed to those agencies.

3. Any costs incurred that are related to fund drives are not reimbursable.

4. Costs incurred for research purposes shall not be included as allowable costs.

5. The cost of services provided under the Title XX program, by contract or subcontract, is specifically excluded as an allowable item.

(N) Other Revenues. Other revenues, including those listed that follow, will be deducted from the total allowable cost, and must be shown separately in the cost report by use of a separate schedule if included in the gross revenue: income from telephone services; sale of employee and guest meals; sale of medical abstracts; sale of scrap and waste food or materials; rental income; cash, trade, quantity time and other discounts; purchase rebates and refunds; parking lot revenues; vending machine commission or profit; sales from drugs to other than recipients;

Medicare Part B revenues; and room reservation charges for temporary leave of absence days which are not covered services under section (6) of this rule. Failure to separately account for any of the revenues specifically set out previously in this rule in a readily ascertainable manner shall result in termination from the program.

(O) Apportionment of Costs to Medicaid Recipient Residents. Provider's allowable cost areas shall be apportioned between the certified ICF/MR portion and the noncertified portion so that the share borne by the Medicaid program is based upon actual services received by program recipients.

(8) Reporting Requirements.

(A) Annual Cost Report.

1. Each provider shall establish a twelve (12)-month period which is to be designated as the provider's fiscal year. An annual cost report for the fiscal year shall be submitted by the provider to the department on forms to be furnished for that purpose. The completed forms shall be submitted by each provider within ninety (90) days following the close of its fiscal year.

2. Unless adequate and current documentation in the following areas have previously been filed with the department, authenticated copies of the following documents must be submitted with the cost reports: authenticated copies of all leases related to the activities of the facility, all management contracts and all contracts with consultants.

3. Adequate documentation for all line items on the uniform cost reports must be maintained by the facility and must be submitted to the department upon request.

4. Following the ninety (90)-day period, payments will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with these rules, the payments that were withheld will be released.

5. If requested in writing, a thirty (30)-day extension of the filing date may be granted for good cause shown.

6. The termination of or by a provider of participation in the program requires that the provider submit a cost report for the period ending with the date of termination. The cost report is due within forty-five (45) days of the date of termination. Cost reports under this paragraph shall conform to the principles of section (7). The final payment due providers shall be withheld until their cost report is filed.

7. Cost reports shall be based upon the provider's financial and statistical records which must be capable of verification by audit.

8. The annual cost report for the fiscal year of the provider may be subject to audit by the Department of Social Services or its contracted agents.

9. The department shall retain the annual cost report and any working papers relating to the audits of the cost reports for a period of not less than seven (7) full years from the date of submission of the report or completion of the audit.

(B) Certification of Cost Reports.

1. The accuracy and validity of any cost report must be certified. Certification must be made by one (1) of the following persons (who must be authorized by the governing body of the facility to make the certification and will furnish proof of authorization): an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner; or for a public facility, the chief administrative officer of the facility. The cost report also must be notarized by a licensed notary public.

2. Certification statement.

Form of Certification

Misrepresentation or falsification of any information contained in this report may be punishable by fine, imprisonment, or both, under state or federal law.

Certification by officer or administrator of provider:

I hereby certify that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared by _____ (Provider name(s) and number(s)) for the cost report period beginning _____, 19____ and ending _____, 19____ and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

_____ _____ _____
(Signature) (Title) (Date)

(C) Adequacy of Records.

1. The provider must make available to the department or its duly authorized agent, including federal agents from the Department of Health and Human Services (HHS), at all reasonable times, records as are necessary to permit review and audit of provider's cost reports. Failure to do so may lead to sanctions stated in paragraph (8)(A)4. of this rule or other sanctions available in section (9).

2. All records associated with the preparation and documentation of the data associated with the cost report must be retained for seven (7) years from the cost report filing date.

(D) Accounting Basis.

1. The cost report submitted must be based on the accrual basis of accounting.

2. Governmental institutions that operate on a cash or modified cash basis of accounting may continue to use those methods, provided appropriate treatment of capital expenditures is made.

(9) Sanctions and Overpayments.

(A) Sanctions may be imposed against a provider in accordance with 13 CSR 70-3.030 and other federal or state statutes and regulations.

(B) In the case of overpayments, the provider shall repay the overpayment in accordance with the provisions as set forth in 13 CSR 70-3.030.

(10) Payment Assurance.

(A) The state will pay each provider, which furnished the services in accordance with the requirements of the state plan, the amount determined for services furnished by the provider according to the standards and methods set forth in these rules.

(B) Where third-party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Service. Procedures for remitting third-party payments are provided in the Missouri Medical Assistance (Medicaid) Program provider manuals.

(11) Provider Participation. Payments made in accordance with the standards and methods described in this rule are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive medical care and services included in the state plan at least to the extent these services are available to the general public.

(12) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full for covered services rendered to Medicaid recipients, the amount paid in accordance with these rules and applicable copayments.

(13) Plan Evaluation. Documentation will be maintained to effectively monitor and evaluate experience during administration of this plan.

(14) Transition. Cost reports used for the determination of the rates and the historical rate of change shall be adjusted by the division in accordance with the cost principles provided in this plan.

APPENDIX A

Routine Covered Medical Supplies and Services

ABD Pads
A & D Ointment
Adhesive Tape
Aerosol Inhalators, Self-Contained
Aerosol, Other Types
Air Mattresses
Air P.R. Mattresses
Airway--Oral
Alcohol
Alcohol Plasters
Alcohol Sponges
Antacids, Nonlegend
Applicators, Cotton-Tipped
Applicators, Swab-Eez
Aquamatic K Pads (water-heated pad)
Arm Slings
Asepto Syringes
Baby Powder
Bandages
Bandages (elastic or cohesive)
Bandaids
Basins
Bed Frame Equipment (for certain immobilized bed patients)
Bed Rails
Bedpan, Fracture
Bedpan, Regular
Bedside Tissues
Benzoin
Bibs
Bottle, Specimen
Canes
Cannula--Nasal
Catheter Indwelling
Catheter Plugs
Catheter Trays
Catheter (any size)

Colostomy Bags
Composite Pads
Cotton Balls
Crutches
Customized Crutches, Canes and Wheelchairs
Decubitus Ulcer Pads
Deodorants
Disposable Underpads
Donuts
Douche Bags
Drain Tubing
Drainage Bags
Drainage Sets
Drainage Tubes
Dressing Tray
Dressings (all)
Drugs, Stock (excluding Insulin)
Enema Can
Enema Soap
Enema Supplies
Enema Unit
Enemas
Equipment and Supplies for Diabetic Urine Testing
Eye Pads
Feeding Tubes
Female Urinal
Flotation Mattress or Biowave Mattress
Flotation Pads, Turning Frames, or both
Folding Foot Cradle
Gastric Feeding Unit
Gauze Sponges
Gloves, Unsterile and Sterile
Gowns, Hospital
Green Soap
Hand-Feeding
Heat Cradle
Heating Pads
Heel Protector
Hot Pack Machine

Ice Bags
Incontinency Care
Incontinency Pads and Pants
Infusion Arm Boards
Inhalation Therapy Supplies
Intermittent Positive Pressure Breathing Machine (IPPB)
Invalid Ring
Irrigation Bulbs
Irrigation Trays
I.V. Trays
Jelly--Lubricating
Laxatives, Nonlegend
Lines, Extra
Lotion, Soap and Oil
Male Urinal
Massages (by nurses)
Medical Social Services
Medicine Cups
Medicine Dropper
Merthiolate Aerosol
Mouthwashes
Nasal Cannula
Nasal Catheter
Nasal Catheter, Insertion and Tube
Nasal Gastric Tubes
Nasal Tube Feeding
Nebulizer and Replacement Kit
Needles (hypodermic, scalp, vein)
Needles (various sizes)
Nonallergic Tape
Nursing Services (all) regardless of level, including the administration of oxygen and restorative nursing care
Nursing Supplies and Dressing (other than items of personal comfort or cosmetic)
Overhead Trapeze Equipment
Oxygen Equipment (such as IPPB machines and oxygen tents)
Oxygen Mask
Pads
Peroxide
Pitcher

Plastic Bib
Pump (aspiration and suction)
Restraints
Room and Board (semiprivate or private if necessitated by a medical or social condition)
Sand Bags
Scalpel
Sheepskin
Special Diets
Specimen Cups
Sponges
Steam Vaporizer
Sterile Pads
Stomach Tubes
Stool Softeners, Nonlegend
Suction Catheter
Suction Machines
Suction Tube
Surgical Dressings (including sterile sponges)
Surgical Pads
Surgical Tape
Suture Removal Kit
Suture Trays
Syringes (all sizes)
Syringes, Disposable
Tape (for laboratory tests)
Tape (nonallergic or butterfly)
Testing Sets and Refills (S & A)
Tongue Depressors
Tracheostomy Sponges
Tray Service
Tubing I.V. Trays, Blood Infusion Set, I.V.
Tubing
Underpads
Urinary Drainage Tube
Urinary Tube and Bottle
Urological Solutions
Vitamins, Nonlegend
Walkers
Water Pitchers
Wheelchairs

Nursing Facility Reimbursement Allowance

(1) Nursing Facility Reimbursement Allowance (NFRA). NFRA shall be assessed as described in this section.

(A) Definitions.

1. Nursing Facility. An institution or a distinct part of an institution which:

A. Is primarily engaged in providing to residents:

(I) Skilled nursing care and related services for residents who require medical or nursing care; or

(II) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

(III) On a regular basis, health-care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases.

B. Has in effect a transfer agreement with one (1) or more hospitals as required by federal law; and

C. Meets the requirements for a nursing facility described in section 1919(b)-(d) of the Social Security Act; or

D. Is licensed in accordance with Chapter 198, RSMo as a skilled nursing facility.

2. Fiscal period. A facility's twelve (12) month fiscal reporting period covering the same twelve (12) month period as its federal tax year.

3. Department. Department of Social Services.

4. Director. Director of the Department of Social Services.

5. Division. Division of Medical Services, Department of Social Services.

6. Division of Aging. The Division of the Department of Social Services responsible for surveys, certification and licensure of nursing facilities.

7. Engaging in the business of providing nursing facility services. Accepting payment for nursing facility services rendered.

8. Patient Occupancy Days. The number of days as shown on the Division of Aging's quarter survey.

9. Total Patient Occupancy Days. The number of patient occupancy days shown on the Division of Aging's quarter survey multiplied by four (4).

10. Licensed Beds. Any Skilled Nursing Facility or Intermediate Care Facility bed meeting the licensing requirement of the Division of Aging or the Missouri Department of Health.

(B) Each nursing facility, except any nursing facility operated by the Department of Mental Health, engaging in the business of providing nursing facility services in Missouri shall pay a Nursing Facility Reimbursement Allowance (NFRA). The NFRA shall be calculated by the Department.

1. The NFRA shall be based on patient occupancy days from the 1996 second quarter survey received from the Division of Aging. The NFRA will be five dollars and thirty cents ($5.30) per patient occupancy day for the period October 1, 1996 through September 30, 1997, and collected over twelve (12) months (November 1996 through October 1997).

2. If a nursing facility did not have patient occupancy day information included on the 1996 second quarter survey from the Division of Aging and is licensed prior to October 1, 1996, the patient occupancy days used to determine the facility's NFRA shall be based on an estimated fifty percent (50%) of licensed beds. This NFRA is for the period October 1, 1996 through September 30, 1997, and collected over twelve (12) months (November 1996 through October 1997).

3. If a nursing facility is licensed after September 30, 1996, their NFRA shall be determined in accordance with paragraph (1)(B)2. of this regulation divided by twelve (12) and prorated for the number of months they are licensed prior to October 1, 1997. Nursing facilities with a licensure date after the first day of any month, the number of months the nursing facility is licensed will be assumed to begin the first day of the month following the actual licensure date. The NFRA will be collected on a prorated basis through October 1997.

(C) Each nursing facility shall submit to the Department a statement that accurately reflects:

1. If the nursing facility is owned and operated by the State of Missouri; and

2. If the nursing facility accepts payment for services rendered.

(D) The Department shall prepare a confirmation schedule of the information from each nursing facility's 1994 second quarter survey from the Division of Aging and provide each nursing facility with this schedule.

1. This schedule shall include:

A. Provider name;

B. Provider number; and

C. Total patient occupancy days.

2. Each nursing facility required to pay the Nursing Facility Reimbursement Allowance shall review the information in the schedule referenced in paragraph (1)(D)1. of this regulation and provide the Department with correct information. If the information supplied by the Department is incorrect, the facility within thirty (30) calendar days of receiving the confirmation schedule must notify the Division and explain the corrections. If the Division does not receive corrected information within thirty (30) calendar days, it will be assumed to be correct, unless the nursing facility files a protest in accordance with subsection (1)(E) of this regulation.

3. Each nursing facility may request that their Nursing Facility Reimbursement Allowance be offset against any Missouri Medicaid payment due to that nursing facility. A statement authorizing the offset must be on file with the Division before any offset may be made relative to the nursing facility reimbursement allowance by the nursing facility. Assessments shall be allocated and deducted over the period covering services January 1995 through September 1995. If no offset has been authorized by the nursing facility, the Division will begin collecting the nursing facility reimbursement allowance on January 1, 1995 and the first day of each month thereafter. If a nursing facility fails to pay its NFRA within thirty (30) days of notice, the NFRA shall be delinquent. For any delinquent NFRA, the Department may proceed to enforce the state's lien of the property of the nursing facility, may cancel or refuse to issue, extend or reinstate the Medicaid provider agreement or may seek denial, suspension or revocation of license granted under Chapter 198, RSMo. The new owner, as a result of a change in ownership, shall have their NFRA paid by the same method the previous owner elected.

4. The nursing facility reimbursement allowance owed or, if an offset has been requested, the balance due, if any, after such offset, shall be remitted by the nursing facility to the Department monthly beginning with January 1995 and each month thereafter. The remittance shall be made payable to the Director of the Department of Revenue. The amount remitted shall be deposited in the state treasury to the credit of the Nursing Facility Reimbursement Allowance Fund.

E. Each nursing facility, upon receiving written notice of the final determination of the Nursing Facility Reimbursement Allowance may file a protest with the Director of the Department setting forth the grounds on which the protest is based, within thirty days from the date of receipt of written notice from the Department. The Director of the Department shall reconsider the determination and, if the nursing facility so requested, the Director or the Director's designee shall grant the nursing facility a hearing to be held within forty-five (45) days after the protest is filed, unless extended by agreement between the nursing facility and the Director. The Director shall issue a final decision within forty-five (45) days of the completion of the hearing. After a final decision by the Director, a nursing facility's appeal of the Director's final decision shall be to the administrative hearing commission in accordance with sections 208.156, RSMo (1986) and 62.155 RSMo (Cum. Supp. 1991).

INSTITUTIONAL STATE PLAN AMENDMENT
ASSURANCE AND FINDING CERTIFICATION STATEMENT

STATE: Missouri TN 97-14

REIMBURSEMENT TYPE:

Nursing facility ✓
ICF/MR ✓

PROPOSED EFFECTIVE DATE: 8/15/97

A. State Assurances and Findings. The State assures that is has made the following findings:

1. 447.253 (b) (1) (i) - The State pays for long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. ✓

2. With respect to nursing facility services –

   a. 447.253 (b) (1) (iii) (A) - Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the costs of complying with the requirements of 42 CFR part 483 subpart B. ✓

   b. 447.253 (b) (1) (iii) (B) - The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30 (c) to provide licensed nurses on a 24-hour basis. ✓

   c. 447.253 (b) (1) (iii) (C) - The State has established procedures under which the data and methodology used to establish payment rates are made available to the public. ✓

3. 447.253 (b) (2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

   a. 447.272 (a) - Aggregate payments made to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. ✓

ARP

JUN 06 2001

b. 447.272 (b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) - - when considered separately - - will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. ✓

If there are no State-operated facilities, please indicate "not applicable:"

B. State Assurances. The State makes the following additional assurances:

1. For nursing facilities and ICFs/MR - -

a. 447.253 (d) (1) - when there has been a sale or transfer of the assets of a NF or ICF/MR on or after July 18, 1984 but before October 1, 1985, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate, solely as a result of a change in ownership, more that payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation. ✓

b. 447.253 (d) (2) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after October 1, 1985, the State's methods and standards provide that the valuation of capital assets for purposes of determining payment rates will not increase (as measured from the date of acquisition by the seller to the date of the change of ownership) solely as a result of a change of ownership, by more than the lesser of:

(i) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Dodge construction index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year; or

(ii) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year. ✓

State Missouri
TN 97-14

2. 447.253 (e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates. ✓

3. 447.253 (f) - The State requires the filing of uniform cost reports by each participating provider. ✓

4. 447.253 (g) - The State provides for periodic audits of the financial and statistical records of participating providers. ✓

5. 447.253 (h) - The State has complied with the public notice requirements of 42 CFR 447.205. ✓

Notice published on: [illegible]

If no date is shown, please explain:

_____

_____

_____

6. 447.253 (i) - The State pays for long-term care services using rates determined in accordance with the methods and standards specified in the approved State plan. ✓

C. Related Information

1. 447.255 (a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: NF, ICF/MR

- Average payment rate did not change as a result of this amendment

Estimated average proposed payment rate as a result of this amendment: $83.73

Average payment rate in effect for the immediately preceding rate period: $83.73

Amount of change: n/a Percent of change: n/a

2. 447.255 (b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:

(a) The availability of services on a statewide and geographic area basis:

none

(b) The type of care furnished:

none

(c) The extent of provider participation:

none